Administrative

MEDICAL CLAIM FORM

Claim Ref:

Patient Name	**: CHIGOZIE FRANCIS ONWUASOANYA**
Card No	**: I040-029-117072633-01**
Policy Holder	**: CHIGOZIE FRANCIS ONWUASOANYA**
Payer Name	**: UNION INSURANCE COMPANY**
TPA	**: E CARE - Blue Network**
Validity	**: 02-01-2024** To **01-01-2025**
Gender	**: Male**
Date Of Birth	**: 04-Sep-1990**
Patient's Tel No	**: 971555429234**

Service Date :09-Sep-2024 **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:Enomen Goodluck**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : Generalized body itching yellowness of the eyes **Duration :**

Vitals: Temp : 36.7 Bp :109 Pulse :66 Resp :18

Clinical Findings:

Diagnosis: K83.1 - Obstruction of bile duct,L29.9 - Pruritus, unspecified,R17 - Unspecified jaundice, **Date of Onset :**09/02/2024

Requested Investigations: 80076, HEPATIC FUNCTION PANEL,85025, BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC COUNT,86140, C REACTIVE PROTEIN,9, Consultation GP **Estimated Cost :**

Prescriptions: 1111-183201-0391 - (FEXOFENADINE HCL : 120 MG) FILM COATED TABLETS, **Estimated Cost :**

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Enomen Goodluck **Stamp :**

Dr. Enomen Goodluck Ekata
General Practitioner
DHA No: 28040827-001
CITICARE MEDICAL CENTER LLC
DUBAI - U.A.E.

Patient 's signature{Parent if minor} : **Date :** 09-Sep-2024

Signature : **Date** : 09-Sep-2024